

## **Section 8: Evaluation Plan for 2004**

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**Updated: September 2003**

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## Introduction

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The HIV/AIDS Administration (HAA) and the HIV Prevention Community Planning Group (HPCPG) have developed this evaluation plan for 2004 following the requirements outlined in the most current evaluation guidance from the Centers for Disease Control and Prevention (CDC), Evaluating CDC Funded Health Department HIV Prevention Programs, 2001; Program Announcement 04012; and the Draft CDC Technical Assistance Guidelines for Health Department HIV Prevention Program Performance Indicators (July 2003).

HAA will review and revise this plan in 2004 to collect and report data as will be specified in the CDC's new Evaluation Guidance and Program Evaluation and Monitoring System (PEMS), to be issued in 2004.

The development and implementation of the evaluation plan is a shared responsibility of HAA and the HPCPG. The evaluation plan is composed of five sections:

1. **Evaluating the Community Planning Process:** This section describes how HAA will monitor and evaluate progress toward meeting the goals and objectives identified in the CDC's Guidance for HIV Prevention Community Planning.
2. **Designing and Evaluating Intervention Plans:** This section describes how HAA will continue to evaluate HIV prevention intervention plans to ensure they are based on the priorities established in the HIV Prevention Plan and are scientifically sound and feasible.
3. **Monitoring and Evaluating the Implementation of HIV Prevention Programs:** This section describes how HAA will continue to assess how funded organizations are implementing HIV prevention interventions, to ensure that contract requirements are met, that they are being implemented in an effective manner and that they are reaching the intended audience.
4. **Evaluating Linkages between the Comprehensive HIV Prevention Plan and Resource Allocation:** This section described how HAA will continue to assess the linkages between the priorities established in the HIV Prevention Plan and the annual funding application, and the linkages between the Plan's priorities and resource allocation.
5. **Monitoring Outcomes of Group-Level Interventions and Prevention Case Management Interventions:** This section describes how HAA will monitor the outcome of Group-Level Interventions and PCM.

In 2003, HAA initiated a data management system named XPRES. The system uses standardized indicators developed in accordance with the current CDC evaluation guidance and local reporting requirements.

In 2004, HAA will add and/or modify the data elements in XPRES to meet all requirements specified in the CDC's new Evaluation Guidance and the new Program Evaluation and Monitoring System (PEMS), to be issued in 2004. HAA will export aggregate data from XPRES in accordance with PEMS specifications.

## 1. Evaluating the Community Planning Process

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The overall goal of HAA and the HPCPG is to monitor and evaluate progress toward meeting the goals and objectives identified in the CDC's Guidance for HIV Prevention Community Planning:

**Goal One** – Community planning supports broad-based community participation in HIV prevention planning.

The Objectives that will be monitored and measured to determine progress in achieving Goal One:

- **Objective A:** Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.
- **Objective B:** Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.
- **Objective C:** Foster a community planning process that encourages inclusion and parity among community planning members.

**Goal Two** – Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

The Objectives that will be monitored and measured to determine progress in achieving Goal Two:

- **Objective D:** Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.
- **Objective E:** Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.
- **Objective F:** Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.

**Goal Three** – Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

The Objectives that will be monitored and measured to determine progress in achieving Goal Three:

- **Objective G:** Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.
- **Objective H:** Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

In addition, HAA and the HPCPG monitor and evaluate progress toward meeting the targets included in the 2004 funding application to the CDC for the following Program Performance Indicators:

**Indicator E.1** Proportion of populations most at risk (up to 10), as documented in the epidemiologic profile and/or the priority populations in the Comprehensive Plan, that have at least one CPG member that reflects the perspective of each population.

**Indicator E.2** Proportion of key attributes of an HIV prevention planning process that CPG membership agrees have occurred.

## **Data Sources**

HAA and the HPCPG will monitor and evaluate the extent to which each HIV prevention community planning objective is met by monitoring whether the 52 attributes for each objective are present in a community planning process (See Appendix). In 2003, HAA developed a management information system (XPRES) for data collection and reporting of all HIV/AIDS service programs. In 2004, HAA will add and/or modify the data elements in XPRES to meet all requirements specified in the CDC's new Evaluation Guidance and the new Program Evaluation and Monitoring System (PEMS), to be issued in 2004. HAA will export aggregate data from XPRES in accordance with PEMS specifications.

The following data sources will be used to monitor and evaluate the community planning process:

- Review of HPCPG Bylaws, policies and procedures
- Review of the HPCPG's Membership Selection Guidelines
- Review HPCPG membership applications and surveys on member demographics
- Conduct an annual survey of the HPCPG membership on the 52 attributes of community planning
- Review the minutes of HPCPG meetings and reports of committee meetings
- Review the District of Columbia HIV Prevention Plan to ensure that it describes the populations prioritized by the HPCPG
- Review the District of Columbia HIV Prevention Plan to ensure that it describes a set of prevention interventions or activities for each target population
- Assess the linkages between the HIV Prevention Plan and the CDC funding application, as well as the linkages between the plan and the funded interventions.

## **Resources**

HAA's Data and Research Division, together with the Prevention and Intervention Services Division and the provider of logistical support to the HPCPG, conducts the evaluation of community planning, including the review of documents and the administration and analysis of surveys.

## Reporting

Reports on the findings of evaluation activities are submitted to the HPCPG for review, and then to the CDC. The reports will document the extent to which the community planning process is meeting the three goals and eight objectives for HIV Prevention Community Planning, and the progress toward meeting the targets for the four community planning Program Performance Indicators. The reports will contain all data elements specified in PEMS. In 2004, HAA will add and/or modify the data elements in XPRES to meet all requirements specified in the CDC's new Evaluation Guidance and the new Program Evaluation and Monitoring System (PEMS), to be issued in 2004. HAA will export aggregate data from XPRES in accordance with PEMS specifications.

## Review

The HPCPG and HAA, after reviewing the reports, will consider what actions to take, if any, to address any deficiencies identified during the evaluation, in order to improve the community planning process.

## The HIV Prevention Community Planning Attributes

**Goal One: Community planning supports broad-based community participation in HIV prevention planning. The following objectives will guide the process of achieving this goal:**

**Objective a:** Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.

**Attribute 1 (Nominations):** Presence of written procedures for nominations to the CPG.

**Attribute 2 (Nominations):** Evidence that written procedures (above) were used for nominations to the CPG.

**Attribute 3 (Nominations):** Evidence that a nominations committee has been established.

**Attribute 4 (Nominations):** Evidence that nominations targeted membership gaps as identified by the community-planning group

**Attribute 5 (Selection):** Evidence that membership decisions involve more than the health department staff.

**Attribute 6 (Selection):** Written documentation of the process for selection of CPG members.

**Attribute 7 (Selection):** Evidence that the process (above) was used in selection of CPG members.

**Objective b:** Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.

**Attribute 8 (Representation):** CPG includes: (a) members who represent populations most at risk for HIV infection as reflected in the current and projected epidemic, as documented in the prior year's epidemiologic profile, and (b) persons living with HIV/AIDS.

**Attribute 9 (Representation):** CPG membership includes members who represent the affected community in terms of race/ethnicity, gender/gender identity, sexual orientation, and geographic distribution.

**Attribute 10 (Representation):** CPG membership includes, or has access to, professional expertise in behavioral/social science, epidemiology, evaluation, and service provision.

**Attribute 11 (Representation):** CPG membership includes, or has access to, key government agencies, including: health department HIV/AIDS program and the state/local health department STD program staff.

**Attribute 12 (Representation):** CPG membership includes, or has access to, key governmental and non-governmental agencies with expertise in factors and issues relative to HIV prevention.

**Objective c:** Foster a community planning process that encourages inclusion and parity among community planning members.

**Attribute 13 (Inclusion):** Evidence of that to gain input from representatives of marginalized groups, who would be hard to recruit and/or retain as CPG members, the CPG convened ad hoc committees, panels, and/or focus groups.

**Attribute 14 (Inclusion):** Evidence that efforts were undertaken to accommodate or facilitate members who face challenging barriers (e.g., health care or economic needs) to their continued participation in the CPG.

**Attribute 15 (Inclusion):** Evidence of a clear decision-making process, including conflict of interest rules.

**Attribute 16 (Inclusion):** Evidence of an orientation, mentoring or training process for new CPG members.

**Attribute 17 (Inclusion):** Evidence that CPG meetings are open to the public and allow time for public comment.

**Attribute 18 (Parity):** Evidence of ongoing training process for all CPG members.

**Goal Two: Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction. The following objectives will guide the process of achieving this goal**

**Objective a:** Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.

**Attribute 19 (Epidemiologic Profile):** The epidemiologic profile provides information about defined populations at high risk for HIV infection for the CPG to consider in the prioritization process.

**Attribute 20 (Epidemiologic Profile):** Strengths and limitations of data sources used in the epidemiologic profile are described (general issues and jurisdiction-specific issues).

**Attribute 21 (Epidemiologic Profile):** Data gaps are explicitly identified in the epidemiologic profile.

**Attribute 22 (Epidemiologic Profile):** The epidemiologic profile contains a narrative interpretation of data presented.

**Attribute 23 (Epidemiologic Profile):** Evidence that the epidemiologic profile was presented to the CPG members prior to the prioritization process.

**Attribute 24 (Community Services Assessment):** The Community Services Assessment (CSA) focuses on one or more high priority populations (i.e., substantially contributing to new HIV infections in a jurisdiction) identified in the epidemiologic profile.

**Attribute 25 (Community Services Assessment):** Data are gathered that define populations' needs in terms of knowledge, skills, attitudes, and norms.

**Attribute 26 (Community Services Assessment):** Data are gathered that define populations' needs in terms of access to services.

**Attribute 27 (Community Services Assessment):** The CSA details the target populations being served.

**Attribute 28 (Community Services Assessment):** The CSA details the interventions provided to each target population.

**Attribute 29 (Community Services Assessment):** The CSA describes the geographic coverage of interventions or programs.

**Attribute 30 (Community Services Assessment):** The CSA was utilized in demonstrating linkages between the application and funded interventions.

**Attribute 31 (Community Services Assessment):** Evidence that prior to the prioritization process, the CPG was provided with a summary of the CSA.

**Attribute 32 (Gap Analysis):** The gap analysis includes data from the epidemiologic profile and CSA.

**Attribute 33 (Gap Analysis):** A gap analysis specifically identifies both met and unmet needs.

**Attribute 34 (Gap Analysis):** The gap analysis identifies the portion of needs being met with CDC funds.

**Attribute 35 (Gap Analysis):** Evidence that prior to the prioritization process, the CPG was provided with a summary of the gap analysis findings.

**Attribute 36 (Gap Analysis):** The gap analysis was utilized by the CPG in demonstrating linkages between the application and funded interventions

**Objective b:** Ensure that priority target populations are based on an epidemiologic profile and a community services assessment.

**Attribute 37 (Target Populations):** Evidence that the size of at-risk populations was considered in setting priorities for target populations.

**Attribute 38 (Target Populations):** Evidence that a measurement of the percentage of HIV morbidity (i.e., HIV/AIDS incidence or prevalence), if available, was considered in setting priorities for target populations.

**Attribute 39 (Target Populations):** Evidence that the prevalence of risky behaviors in the population was considered in setting priorities for target populations.

**Attribute 40 (Target Populations):** Target populations are defined by transmission risk, gender, age, race/ethnicity, HIV status, and geographic location.

**Attribute 41 (Target Populations):** Target populations are rank ordered by priority, in terms of their contribution to new HIV infections.

**Objective c:** Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended consumers for cultural appropriateness, relevance, and acceptability.

**Attribute 42 (Prevention Activities/Interventions):** Demonstrated application of existing behavioral and social science, and pre- and post-test outcome evidence (including evaluation date, when available) to show effectiveness in averting or reducing high-risk behavior within the target population.

**Attribute 43 (Prevention Activities/Interventions):** Evidence that the prevention activity/intervention is acceptable to the target population (e.g., testing, focus groups, etc.).

**Attribute 44 (Prevention Activities/Interventions):** Evidence that the prevention activity/intervention is feasible to implement for the intended population in the intended setting.

**Attribute 45 (Prevention Activities/Interventions):** Evidence that the prevention activity/intervention was developed by or with input from the target population.

**Attribute 46 (Prevention Activities/Interventions):** Prevention activities/interventions are characterized by focus, level, factors expected to affect risk, setting, and frequency/duration.

**Attribute 47 (Prevention Activities/Interventions):** Each prevention activity/intervention is also characterized by scale and significance.

**Attribute 48 (Prevention Activities/Interventions):** Prevention activities/interventions are prioritized by risk population and their ability to have the greatest impact on decreasing new infections.

**Goal Three — Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan. The following objectives will guide the process of achieving this goal**

**Objective a:** Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.

**Attribute 49 (Comprehensive Plan):** Explicit demonstration of linkages between the comprehensive HIV prevention plan and the health department application to CDC for federal funding.

**Attribute 50 (Comprehensive Plan):** Letter of Concurrence.

**Objective b:** Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

**Attribute 51 (Comprehensive Plan):** Explicit demonstration of linkages between the comprehensive HIV prevention plan and funded interventions.

**Attribute 52 (Community Services Assessment):** Explicit demonstration that the CPG has used the CSA to determine whether interventions were funded according to the comprehensive HIV prevention plan.

## 2. Designing and Evaluating Intervention Plans

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In 2004, HAA will continue to evaluate the HIV intervention plans of HAA-funded organizations to ensure that the plans:

- are developed in accordance with the recommendations and priorities of the HIV Prevention Plan and the requirements of solicitations issued by HAA;
- are scientifically sound and feasible;
- meet the requirements, guidance and standards found in Volume 2 of the HIV Prevention Plan for 2003-2004, Guidance and Standards for HIV Prevention Interventions, in the Addendum to Volume 2, published in September 2003, and in HAA's requests for proposals (RFPs) and requests for application (RFAs);
- are implemented as intended.

The assessment of the design and evaluation of intervention plans are undertaken through the process of reviewing applications for funding. The process includes:

- Development RFPs and RFAs, as well as other types of solicitations, based on the priorities set by the HPCPG in the HIV Prevention Plan, as well as the guidance and standards on HIV prevention interventions contained in Volume 2 of the HIV Prevention Plan and the 2003 Addendum to Volume 2.

The solicitations will require that the applicants show evidence that their services focus on those most at risk of transmitting or acquiring HIV infection, reflecting the priorities established in the Comprehensive HIV Prevention Plan, and that programs and interventions:

- Are based on scientific theory, or have evidence of demonstrated or probable outcome effectiveness;
  - Are directed by written procedures or protocols;
  - Are acceptable to and understood by the target population, i.e., are culturally and linguistically appropriate; and
  - Have quality assurance and evaluation procedures in place.
- External and internal reviews of the proposals and applications submitted in response to the solicitations to ensure that they meet the RFP/RFA requirements
- Negotiations with candidates for funding to review and or revise the intervention plans, if needed, so they comply with the requirements of the solicitations, based on the reviewers' recommendations.

The grant-making and contract-making process for the Department of Health, including the HIV/AIDS Administration, is managed and certified by independent entities set-up for this purpose. For HAA, the solicitation of proposals and applications (i.e. RFAs and RFPs), external reviews, evaluation of applications and proposals, and the certification of final decisions, are done by two independent D.C. government agencies: the Office of Research and Analysis and

the Office of Contracts and Procurement. HAA provides staff liaisons to these offices to ensure that intervention plans reflect prevention priorities, and that program designs meet HAA and CDC standards.

## **Development of Solicitations**

By October 30<sup>th</sup> of each year, HAA's Prevention Division will review the standard language of solicitations to ensure that they clearly require that applicants follow the guidance and standards on interventions contained in the HIV Prevention Plan in their funding applications and proposals. HAA will also review the requirements of the RFPs and RFAs to ensure that they request information that will give HAA a clear understanding of the soundness of the prevention programs and interventions being proposed. At a minimum, the solicitations will require the following information:

### **1. Assessment of Need and Justification for the Proposed Activities**

- Documentation of the need for the proposed program and activities and the degree to which the proposed activities are consistent with the HIV Prevention Plan;
- A description of the specific behaviors and practices that the interventions are designed to promote and prevent;
- Documented experience, capacity, and ability to address the identified needs and implement the proposed activities, including:
  - a. How the applicant's organizational structure and planned collaborations will support the proposed program activities, and how the proposed program will have the capacity to reach targeted populations;
  - b. Applicant's past and current experience in developing and implementing effective HIV prevention strategies and activities, and in developing and implementing programs similar to those proposed in the application;
  - c. Applicant's experience and ability in collaborating with governmental and non-governmental organizations, including the Health Department, the HPCPG, and other organizations that provide HIV prevention services;
  - d. Applicant's capacity to obtain meaningful input and representation from members of the target population/s and to provide culturally competent and appropriate services which respond effectively to the cultural, gender, environmental, social, and multilingual character of the target audiences, including documentation of any history of providing such services; and
  - e. Plans to ensure capacity to implement proposed program where no direct experience or capacity currently exists within the applicant organization.

### **2. Program Plan**

- A description of the involvement of the target population in planning, implementing, and evaluating activities and services throughout the project period.

- Process and outcome objectives that are specific, measurable, appropriate, realistic, and time-based, related to the proposed activities, and consistent with the program's long-term goals; and the extent to which the applicant identifies possible barriers to or facilitators for reaching these objectives.
- A plan for conducting program activities.
- A description of how the proposed interventions and services are culturally competent, sensitive to issues of sexual orientation, developmentally appropriate, linguistically-specific, and educationally appropriate.
- Intervention plans that are based on formal behavioral science theory, social science theory, or some other theory that is published in the scientific literature, and that explain how the theory is integrated into the content, format and delivery of the intervention.
- A detailed description of the system to be used by the organization to track referrals to counseling and testing, early intervention and other services, for the purpose of evaluating the effectiveness of referrals made as part individual- and group-level interventions and prevention case management.
- A detailed description of the organization's plan to conduct a process evaluation of all interventions and outcome monitoring of individual-level and group-level interventions and prevention case management. The evaluation plan should include a plan for collecting data that includes number of clients to be reached, categorized by race/ethnicity and gender, data sources, staff responsibilities for collecting and reporting the data, and a protocol for how the system will be implemented.

In addition, the organization must describe how it will collect and report the data needed to determine the progress in meeting HAA's targets for the CDC's Program Performance Indicators for Counseling, Testing and Referral Services; Partner Counseling and Referral Services; Perinatal Transmission Prevention; Health Education/Risk Reduction; and Indicator I.1 for Prevention for Infected Persons.

- A description and documentation of the current and proposed collaboration and coordination with other organizations serving the same priority population/s.
- A timeline that is specific and realistic.

HAA will ensure that each solicitation is based on the priorities set in the HIV Prevention Plan and that it covers all requirements associated with the implementation of the particular intervention/s that organizations are being asked to implement.

## **External and Internal Review of the Applications**

The Office of Research and Analysis and the Office of Contracts and Procurement coordinate the external review of proposals and applications in response to the RFAs and RFPs issued by HAA. The external review teams use forms that outline the criteria for review and assigns scores to each criterion listed above. Additionally, reviewers make recommendations for changes if they find a proposal or application could be funded if the applicant makes changes to meet all requirements.

The external review agencies assemble all of the written reviews and provide HAA with the completed External Evaluation Forms, a summary report listing the scores assigned by the reviewers, and any comments or recommendations made by the reviewers, including recommendations for funding.

Additionally, HAA staff conducts an internal review of all the applications, using an Internal Evaluation Form, which is also guided by review criteria to further assure that intervention plans meet HAA and CDC standards, and the most qualified applicants are considered for funding. HAA management reviews the results of the external and internal evaluations to determine if there are any major differences in the external and internal reviewers' scores and recommendations. If there are, a more detailed examination is undertaken, in order to reach consensus. The external review agencies then review and certify all results.

### **The Development of the Grant Agreement**

HAA considers all of the scores and recommendations in selecting which programs to fund. Based on these considerations and recommendations provided by the external and internal review teams, HAA staff meets with the prospective grantee. Each organization has the opportunity to respond to issues of concern identified in the review. Corrective measures are then negotiated prior to the signing the grant agreement to ensure that funded interventions will reflect the priorities and guidelines set in the HIV Prevention Plan, as well as the requirements of the solicitation. This process also allows HAA and the organization to identify any areas in which the organization may need technical assistance for the development, implementation or evaluation of the interventions.

### **Needs Assessment**

In 2004 HAA will conduct an assessment of all HAA- and CDC-funded CBOs to determine their capacity to design, implement and evaluate HIV prevention programs, including their capacity to provide outreach testing and partner counseling and referral services. The assessment will use self-administered questionnaires and interviews with agency staff, as well as site visits, and will produce individual reports for each organization as well as a summary to identify system-wide needs.

Based on the assessment, HAA will design and implement a four-year strategic plan to provide capacity building technical assistance and training to HAA- and CDC-funded organizations to design, implement, and sustain prevention interventions for persons living with HIV/AIDS and other prioritized target populations.

Starting in 2005, HAA will assess the capacity of newly funded organizations each year. A follow up survey of all organizations will be conducted in 2007.

### **3. Monitoring the Implementation of HIV Prevention Programs**

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HAA's Prevention and Intervention Services Division will continue to monitor the implementation of HAA-funded HIV prevention programs in 2004, to document the characteristics of the individuals reached through prevention interventions, the services that were provided, and the resources that were used to deliver those services.

HAA will focus on collecting and reporting data on meeting the targets for the program performance indicators in the areas of Overall HIV; Counseling, Testing and Referral Services; Partner Counseling and Referral Services; Perinatal Transmission Prevention; Health Education/Risk Reduction; Evaluation; Capacity Building, and indicator I.1 for Prevention for Infected Persons.

The monitoring process ensures that contract requirements are met and that the interventions are being implemented in an effective manner; to help the funded organizations and HAA determine if any changes are needed in the implementation of the funded programs to improve the delivery of services; and to help HAA and the funded organizations determine the technical assistance needs of the providers.

HAA will monitor and collect all process outcomes specified in the CDC's new Evaluation Guidance and Program Evaluation and Monitoring System (PEMS), to be issued in 2004. HAA's evaluator will work with the Division's Project Officers to monitor the implementation of the grants, and coordinate all data collection and analysis activities, and prepare the aggregate reports to be submitted to the CDC quarterly.

HAA will collect and report process data in order to measure performance in meeting the targets set in the CDC funding application for 2004, for the following Program Performance Indicators. In 2004, HAA will add and/or modify the data elements in XPRES to meet all requirements specified in the CDC's new Evaluation Guidance and the new Program Evaluation and Monitoring System (PEMS), to be issued in 2004. HAA will export aggregate data from XPRES in accordance with PEMS specifications.

#### **Overall HIV**

**A.1:** Number of newly diagnosed HIV infections.

**A.2:** Number of newly diagnosed HIV infections, 13–24 years of age.

#### **Counseling, Testing, and Referral Services**

**B.1:** Percent of newly identified, confirmed HIV-positive test results among all tests reported by HIV counseling, testing, and referral sites.

**B.2:** Percent of newly identified, confirmed HIV-positive test results returned to clients.

**B.3:** Percent of facilities reporting a prevalence of HIV positive tests equal to or greater than the jurisdiction's target set in B.1.

#### **Partner Counseling and Referral Services**

**C.1:** Percent of contacts with unknown or negative serostatus receiving an HIV test after PCRs notification.

**C.2:** Percent of contacts with a newly identified, confirmed HIV-positive test among contacts who are tested.

**C.3:** Percent of contacts with a known, confirmed HIV-positive test among all contacts.

### **Perinatal Transmission Prevention**

**D.1:** Proportion of women who receive an HIV test during pregnancy. Pregnant women's knowledge of their serostatus

**D.2:** Proportion of HIV-infected pregnant women who receive appropriate interventions to prevent perinatal transmission.

**D.3:** Proportion of HIV-infected pregnant women whose infants are perinatally infected.

**D.4:** Proportion of women who receive an HIV test during pregnancy.

### **Evaluation**

**F.1 :** Proportion of providers reporting representative process monitoring data to the health department in compliance with CDC program announcement.

### **Capacity Building**

**G.1:** Proportion of providers who have received at least one health department supported capacity building assistance episode, specifically in the form of trainings/workshops in the design, implementation or evaluation of science-based HIV prevention interventions.

### **Health Education/Risk Reduction**

**H.1:** Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), group level interventions (GLI), and Prevention Case Management (PCM).

**H.2:** Proportion of the intended number of the target populations to be reached with any of the following specific interventions (ILI or GLI or PCM) who were actually reached.

**H.3:** The mean number of outreach contacts required to get one person to access any of the following services: Counseling & Testing, Sexually Transmitted Disease Screening & Testing, ILI, GLI or PCM.

### **Prevention for HIV Infected Persons**

**I.1:** Proportion of HIV infected persons that completed the intended number of sessions for Prevention Case Management.

### **Data Collection**

In 2003, HAA initiated a data management system named XPRES. The system uses standardized indicators developed in accordance with the current CDC evaluation guidance and local reporting requirements. In 2004 HAA will review and ensure the compatibility of the data elements in the XPRES database with the requirements of the CDC's new Evaluation Guidance and Program Evaluation and Monitoring System (PEMS).

In 2004, HAA will add and/or modify the data elements in XPRES to meet all requirements specified in the CDC's new Evaluation Guidance and the new Program Evaluation

and Monitoring System (PEMS), to be issued in 2004. HAA will export aggregate data from XPRES in accordance with PEMS specifications.

HAA will provide technical assistance such as workshops and on-site training to sub-grantees ensuring the full implementation of XPRES. To ensure the quality of all data collection activities HAA will take the following steps:

- The instrument is comparable across sites and is in accordance with CDC reporting requirements
- Ensure that the data elements can be adapted across the programs
- Provide explicit written instructions and procedures of how to complete each data element, data to report and reporting dates
- Provide training to CBOs
- Provide the instrument in both electronic and hard copy version
- Test and ensure the clarity and appropriateness of the instrument, instructions and procedures
- Monitor data collection – site visits and scheduled reports about barriers
- Quarterly and yearly reports

#### 4. Evaluating Linkages Between the HIV Prevention Plan, the CDC Funding Application and Resource Allocation

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HAA evaluates the linkages between the HIV Prevention Plan and the annual application for funding to ensure that the populations for whom services will be funded and the interventions to be funded for those populations match the priorities and recommendations of the Prevention Plan. A similar assessment is conducted for all interventions funded by the CDC with supplemental funds, as well as for interventions funded with District-appropriated dollars. Whenever there is a deviation from the recommendations, it must be justified to the HPCPG and the CDC.

HAA will continue to conduct these assessments during the project period, using the following two tables, or tables included in the new Evaluation Guidance to be issued by the CDC in 2004:

Target Populations and Interventions	Interventions in the CDC Funding Application	
	... that match a recommendation in the plan	...that do not match a recommendation in the plan
Target Population #		
Intervention #1		
Intervention #2		
Intervention #3		

Target Populations and Interventions	Interventions to be funded by the Department of Health...	
	... that match a recommendation in the plan	...that do not match a recommendation in the plan
Target Population #		
Intervention #1		
Intervention #2		
Intervention #3		

The review of prevention programs funded by HAA with CDC and health department funds will include a review of all grant agreements to determine which interventions recommended in the Plan were funded, which recommended interventions were not funded, and which interventions that were not recommended were funded. Whenever there is a deviation from the recommendations, the Division's evaluator will seek to determine the reason/s and make recommendations to the HPCPG regarding future prioritization of populations and/or interventions if warranted by circumstances (e.g. no organization applied for the funding, an emerging population that was not prioritized is receiving services, or an organization is implementing an intervention that was not recommended but was deemed necessary to supplement other interventions, such as providing individual prevention counseling to participants in group-level interventions).

HAA will evaluate linkages between the HIV Prevention Plan and resource allocation annually, comparing the interventions funded in the previous year with interventions recommended in the prevention plan for that year. HAA will use the CDC's worksheets to determine whether funded interventions match or do not match a recommendation in the HIV Prevention Plan in the preparation of the annual funding application and the annual progress report.

### **Program Performance Indicators**

HAA and the HPCPG will monitor and evaluate progress toward meeting the targets included in the 2004 funding application to the CDC for the following Program Performance Indicators:

**Indicator E.3** Percent of prevention interventions/other supporting activities in the health department CDC funding application specified as a priority in the comprehensive HIV prevention plan.

**Indicator E.4** Percent of health department-funded prevention interventions/other supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan.

## 5. Monitoring Outcomes of Group-Level Interventions and Prevention Case Management

### Introduction

Outcome monitoring refers to efforts to track the progress of clients or a program based upon outcome measures set forth in program goals and objectives. These measurements assess the effects of specific intervention activities on client knowledge, attitudes, beliefs and behaviors (KABB). Anticipated outcomes should be stated in measurable terms in intervention plans and based on a program model (e.g., there should be a basis in formal or informal theory).<sup>1</sup>

This section of the evaluation plan describes the steps that HAA will take to implement outcome monitoring of group-level interventions and prevention case management interventions implemented by HAA-funded CBOs.

Since December 2000, HAA has required that those sub-grantees that provide individual-level interventions, prevention case management and group-level interventions conduct outcome monitoring of those interventions. In 2001, HAA assessed the evaluation capacity of each sub-grantee. The assessment found that the majority of the HIV prevention sub-grantees required some level of capacity building technical assistance in outcome monitoring and other evaluation activities.

HAA decided to provide capacity building training and technical assistance in outcome monitoring to all HAA prevention sub-grantees, including workshops and individual consultation. In addition, HAA provided more intensive assistance to sub-grantees that would conduct outcome monitoring of GLIs in 2003 and 2004.

Based on the findings of the study, HAA provided technical assistance through a sub-contractor to five CBOs in 2002 (approximately 20% of HAA's sub-grantees) to increase their capacity to conduct outcome monitoring of GLIs. The assistance included the development of curricula that had measurable objectives related to changes in knowledge, attitudes, beliefs and behaviors.

HAA chose to begin with outcome monitoring of GLIs because GLIs are prioritized for approximately 80% of the prioritized populations, they reach a relatively large target audience, and changes in KABB can be measured through pre- and post-intervention tests.

In 2003 the five organizations are conducting outcome monitoring of GLIs with the assistance of the technical assistance provider. Additional sites may be added in 2004.

In 2004, HAA will gather the information on the results of the outcome monitoring at the end of each quarter and submit reports to the CDC using the new PEMS system. In 2004, HAA will add and/or modify the data elements in XPRES to meet all requirements specified in the CDC's new Evaluation Guidance and the new Program Evaluation and Monitoring System (PEMS), to be issued in 2004. HAA will export aggregate data from XPRES in accordance with PEMS specifications.

HAA will continue to data on the changes in knowledge, attitudes, beliefs and behaviors for all participants in ILI, PCM and GLI. In addition, HAA will collect and report outcome data in

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<sup>1</sup> CDC Guidance III-16 & VI-3

order to measure performance in meeting the targets set in the CDC funding application for 2004, for the following Program Performance Indicator:

**I.2:** Percent of HIV infected persons who, after a specified period of participation in Prevention Case Management, report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with seronegative partners or with partners of unknown status.

### **Site Selection for Outcome Monitoring**

In March 2001 HAA conducted an assessment of the evaluation capacity of all prevention sub-grantees. The primary purpose of the assessment was to determine sub-grantees' level of readiness to conduct an outcome monitoring evaluation. Specifically, the instrument assessed whether or not the sub-grantees:

- Have in place curricula or program guidance documents with measurable goals and objectives
- Have an outcome monitoring plan
- Have instruments to monitor intervention implementation
- Have pre-intervention, post-intervention and follow up instruments to measure changes in KABB based on their outcome objectives, and instruments to assess participant satisfaction with the intervention
- Have database systems and statistical software in place (i.e., SPSS) and familiarity with the statistical software
- Have a data analysis plan
- Have reports summarizing outcome monitoring activities, findings, and recommendations from prior interventions
- Have implemented changes in their programs as result of those monitoring activities
- Have avenues for disseminating the findings of outcome monitoring

In addition to assessing the CBOs' readiness to conduct outcome monitoring, the instrument assessed the organizational characteristics of the sub-grantees, including fiscal stability, infrastructure, targets served, types of programs conducted and the evaluation capacity of their staff. Upon careful analysis of the assessment, HAA determined that most sites would require capacity building before engaging in outcome monitoring.

HAA decided to implement a two-pronged approach: to provide training on evaluation for all sub-grantees and to provide intensive training and technical assistance to the six CBOs that were selected to participate in the 2002 and 2003 outcome monitoring activities. The capacity building activities began with two days of training on evaluation in May 2001 and again in the last quarter of 2002.

A subcontractor with expertise in conducting CBO evaluations is providing the general training on evaluation for all sub-grantees. This same capacity building provider will assist HAA staff to provide intensive capacity-building training and technical assistance to the sites selected for the outcome monitoring activities. A participatory process involving HAA and those sub-grantees will drive the capacity building activities. During this period, HAA will continuously assess the sub-grantees progress and will document results and recommendations.

### III. Preparing Selected Sites for Outcome Monitoring

All capacity building activities are specifically designed to prepare and assist each of the ~~six~~ sub-grantees to conduct outcome monitoring. This includes preparing sites for outcome monitoring, implementing an outcome monitoring and synthesizing and sharing outcome-monitoring findings. HAA will assist this group of sub-grantees to prepare to implement outcome monitoring of their group level intervention. HAA will provide individualized technical assistance to the sub-grantees, as needed, during the implementation of outcome monitoring and report writing. The following describes the steps HAA will take to assist each sub-grantee in preparing for and implementing outcome monitoring. Upon the completion of each of the following steps, HAA will document progress, results and recommendations.

#### Step 1: Content Analysis of Intervention Material

HAA **will work** closely with each sub-grantee and conduct a content analysis of all intervention materials at each site. The purpose of the content analysis will be to ensure the existence of relevant and scientifically sound intervention curricula or intervention guidance. Intervention materials could include needs assessment data, intervention curricula, pre-existing evaluation instruments, pre-existing data or reports. Special care will be taken to determine if intervention outcome objectives and intervention activities are responsive to the needs of the community. Table 1 provides guidance on evaluating the relevance and scientific soundness of interventions.

**Table 1: Evaluating the Choice of Interventions <sup>2</sup>**

Relevance	Interventions that correspond with high priority strategies in the comprehensive HIV prevention plan reflect the central issues of HIV prevention community planning: "Does health department resource allocation mirror the strategies prioritized in the comprehensive HIV prevention plan?" In terms of relevance, an intervention that is consistent with a priority in the comprehensive HIV prevention plan (or a previous needs assessment at the local level) can be considered relevant to the jurisdiction.
Scientific Soundness	The scientific merit of a proposed intervention can be evaluated in terms of: 1) Whether the intervention has a basis in scientific evidence 2) The anticipated strength and duration of the intervention

<sup>2</sup> CDC Guidance III-15

	Scientific evidence can be in the form of prior evaluation or research that supports the intervention approach or a theory that provides testable assumptions about the relationship between the intervention and its intended outcomes. The more similar the populations and settings of the prior research, the greater the likelihood that the proposal intervention will be similar to prior research findings.
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Upon determining that an intervention is relevant and scientifically sound, the content analysis will focus on the quality of the outcome objectives. Well-written outcome objectives provide the foundation for measuring intervention effectiveness. They are statements of the intended effects of the intervention, such as increasing knowledge about HIV, changing risk-related behavior, promoting community norms for safer sex and reducing HIV transmission.<sup>3</sup> Outcome objectives are derived from a careful needs assessment and a review of the scientific literature to assess “best practices” in HIV prevention. Table 2 below describes the components of well-written or SMART outcome objectives.

**Table 2: SMART Characteristics of Goals and Objectives**

<b>Characteristics</b>	<b>Questions to Guide the development of goals and objectives</b>
<b>Specific</b>	<ul style="list-style-type: none"> <li>• Are objectives stated as changes in particular behaviors?</li> <li>• Is the amount of change expected made explicit?</li> <li>• Can the change be achieved through one intervention?</li> </ul>
<b>Measurable</b>	<ul style="list-style-type: none"> <li>• Can the objective be measured in such a way that the success of the intervention can be determined?</li> <li>• Can these numbers or facts be presented in a report?</li> <li>• Are there data to compare these data with? (e.g., from a baseline or a control group)</li> </ul>
<b>Appropriate</b>	<ul style="list-style-type: none"> <li>• Are these objectives culturally and educationally appropriate?</li> <li>• How will the community accept this program?</li> <li>• Does the intervention fill a gap in current services?</li> </ul>
<b>Realistic</b>	<ul style="list-style-type: none"> <li>• Are the goals and objectives attainable given the level of risk and the anticipated difficulty changing the risk behavior(s)?</li> <li>• Can the providing agency implement the proposed intervention?</li> <li>• Are the resources available to achieve the stated objectives?</li> </ul>

Once HAA is certain that an intervention is predicated on SMART outcome objectives, the next step in the content analysis will be to examine the linkages between the outcome objectives and process objectives. Process objectives focus on the projected amount,

<sup>3</sup> CDC Guidance, VI-3-5

frequency, and duration of intervention activities and the number and characteristics of people to be served.<sup>4</sup> Table 3 below illustrates the connection between SMART outcome objectives, program implementation, and outcome monitoring.

**Table 3**

<b>SMART Outcome Objectives</b>	<b>Process Objectives</b>	<b>Outcome monitoring</b>
HIV Prevention → Program Implementation	HIV Prevention → Measure Pre-Post Changes in Knowledge, Attitudes, Beliefs, Behaviors	Intervention Plan
<i>Good Intervention and Implementation Plans Provide a Foundation for Prevention Outcomes!</i>		

Adapted from CDC Guidance, VI-1

Upon completion of the content analysis, HAA will be able to identify areas where sites need assistance in developing or modifying their existing intervention plans. As needed, sites will be given assistance with a range of intervention planning activities such as conducting further needs assessments to ensure intervention relevance; assisting sites with developing SMART outcome objectives; developing corresponding process objectives; and identifying existing curricula or developing new curricula. When the group-level interventions have SMART objectives and structured curricula, HAA will assist the sites in developing an outcome-monitoring plan.

## **Step 2: Develop Outcome Monitoring Evaluation Plan**

HAA will work closely with each selected sub-grantee to develop their outcome-monitoring plan. For each data collection activity, the outcome monitoring plan will describe the data collection sources, data collection methods, key evaluation questions to be answered, the time line for developing instruments and collecting data (e.g., pre/post/follow-up), and who is responsible for instrument development and survey administration. The outcome monitoring evaluation plan will be the blueprint that guides all data collection activities and will help to keep all parties on task and on time.

## **Step 3: Develop Instruments to Monitor Intervention Implementation**

In order to determine if the intervention is being implemented as planned, HAA will assist sites with the development of tracking logs to monitor program implementation. The tracking logs will help sites to determine the extent to which the intervention is being implemented with fidelity; the barriers and supports encountered during implementation, and

<sup>4</sup> CDC Guidance, VI-3-5

intervention areas that need improvement. It will be essential to monitor implementation of the intervention when conducting outcome monitoring. Careful monitoring, using the tracking logs, will help to ensure that the intervention is being implemented as planned and that the outcome objectives can be accurately measured.

#### **Step 4: Develop Instruments to Measure Changes in KABB and Participant Satisfaction**

HAA will assist sites with the development of instruments to measure changes in KABB and participant satisfaction. The pre-test, post-test, and follow up instruments will be developed specifically to measure achievement of the outcome objectives. For example, each survey item will be carefully crafted to measure intended outcomes in participants' knowledge, attitudes, beliefs, and behaviors as set forth in the outcome objectives. Relevant socio-demographic information will also be collected. A participant satisfaction survey will be developed and administered at the same time as the post-test. The satisfaction survey will assess participants' perceptions of the intervention including strengths, weaknesses, recommendations for improvement, and satisfaction with specific intervention components (e.g., specific activities) and characteristics (e.g., facilitators etc.)

#### **Step 5: Ensure Sites Have Database Management Systems in Place (i.e., SPSS)**

HAA will work closely with each site to ensure that project staff has the necessary systems in place to enter and analyze data collected during the outcome monitoring evaluation. In addition, HAA will provide each site with the necessary training and support to ensure that staff are comfortable using the statistical software, that they can develop a simple data analysis plan, and that they can execute that plan to examine their outcome monitoring data. Outcome monitoring plans will be developed in accordance to CDC's reporting requirements.

Once the GLI curricula is fully prepared, instruments are developed, sites have statistical data bases in place, and staff have been trained to design and execute basic data analysis plans, sites will be ready to implement their outcome monitoring plan. At this point, the role of the capacity building provider is complete and HAA prevention staff will step in to provide technical assistance as site implement their outcome monitoring plans.

### **IV. Implementation of the GLI Outcome Monitoring Plan**

In years 2002 and 2003, the initiation of outcome monitoring activities will be staggered across sites. In 2002, three sub-grantees will conduct outcome monitoring. Due to variations in the life cycles of interventions across the sites (they will naturally begin and end at different times), the order of selection will be dependent on when each site's intervention begins and their readiness to engage in outcome monitoring. HAA expects that the first site will be ready to begin data collection no later than the end of January 2002, the second by the end of February 2002 and the third by the end of March. 2002.

### **Step 1: Data Collection**

In order to ensure appropriate methodology, HAA will assist sites in developing data collection procedures. Technical assistance will include development of introduction / instructions to survey instruments, informed consent, confidentiality, referral information, and the correct use of unique identifiers to track respondents pre, post and follow-up.

### **Step 2: Data Entry, Cleaning, and Analysis**

HAA will request that sites enter all data within two weeks of data collection. HAA prevention staff will provide technical assistance to ensure that site staff are entering and cleaning the data properly. Once the data is entered and clean, site staff will execute the data analysis plan. The plan will consist of frequency analysis or descriptive statistics of all variables including demographics. In addition, appropriate inferential analysis (e.g., T-tests, ANOVA) will be conducted to examine pre to post test changes in KABB and participant satisfaction.

### **Step 3: Report Writing**

Each sub-grantee will prepare for HAA an interim and a final report of their outcome monitoring activities. The interim reports will include a detailed description of the target population, the intervention, and findings from implementation tracking logs and findings from the pre-tests. In addition, the sub-grantee will summarize the findings and discuss any mid-course modifications that need to be made to the intervention as a result of the data. Additionally, each sub-grantee will address barriers and supports faced in implementing their programs.

Upon completion of the outcome monitoring activities for program year 2002, each sub-grantee will prepare and submit a final written report to HAA. The final report will include all information recorded in the interim report or any modification implemented either in the design of the intervention activity or the delivery as a result of the first phase of the evaluation. The final report will include aggregated information about the Group-Level HIV Prevention Intervention:

- Objectives
- Methodology
- Target population
- KABB analysis results
- Effectiveness of the intervention in changing perception and risk behaviors among participants.
- Barriers encountered in implementing the program
- Participants' satisfaction with the program
- Recommendations for program improvement
- Copies of all data collection instruments

#### **Step 4: Integrate Outcome Monitoring Findings**

HAA will conduct a debriefing meeting with each sub-grantee to discuss lessons learned, to assess reaction to the outcome monitoring process, and to identify avenues to disseminate findings (i.e., HPCPG sub-committees and work groups, local conferences, and cross site sub-grantees). HAA will gather all of the information and review lessons learned. HAA will incorporate the recommendations into existing programs, technical assistance activities, future program solicitations instruments (request for applications, request for proposals, etc.) and community planning activities.

#### **Reports from HAA to the CDC**

HAA will add and/or modify the existing data elements in XPRES to meet all PEMS specifications with regards to outcome monitoring. HAA will provide technical assistance such as workshops and on-site training to sub-grantees ensuring the full implementation of XPRES. To ensure the quality of all data collection activities HAA will take the following steps:

After the implementation of outcome monitoring activities is completed, HAA will review the data submitted by the sub-grantees. Using the CDC reporting requirements, HAA will review each report, aggregate the data in accordance with the guidelines, and implement the appropriated procedures of exporting the information from XPRES to PEMS. The following elements will be updated upon the full disclosure of PEMS specification:

- Names and affiliations of evaluators conducting the outcome monitoring
- Intervention Type/s
- Intervention goals and outcome objectives
- Target population/s
- Evidence and justification for the intervention
- Copy of Instruments/Data collection tools
- Methods of data collection and statistical analysis
- Appropriate descriptive statistics, including client demographics
- Summary of findings
- How results will be used for program improvement

The sites that conducted outcome monitoring with individualized TA in 2002 also participate in 2003. This gave them the opportunity to improve their interventions in 2003 based upon lessons learned in 2002. Three additional sites were added in 2003 for a total of 6 sites in that year. As with 2002, 2003 sites initiated outcome-monitoring activities based on the order in which they commence and their level of readiness to begin collecting data.

## **Monitoring PCM**

In 2003 HAA will conduct a new needs assessment of its sub-grantees to determine if those organizations that provide PCM:

- Have an outcome monitoring plan for PCM
- Have instruments to monitor intervention implementation
- Have reports summarizing outcome monitoring activities, findings, and recommendations from prior interventions
- Have implemented changes in their programs as result of those monitoring activities
- Have avenues for disseminating the findings of outcome monitoring

The assessment will also seek to determine if the sub-grantees are implementing prevention case management that is based on the 1998 CDC guidance and includes the following components:

- Client recruitment and engagement;
- Screening and assessment (comprehensive assessment of HIV and STD risks, medical and psychosocial service needs - including STD evaluation and treatment, and substance abuse treatment);
- Development of a client-centered "Prevention Plan;"
- Multiple-session HIV risk-reduction counseling;
- Active coordination of services with follow-up;
- Monitoring and reassessment of clients' needs, risks, and progress; and
- Discharge from PCM upon attainment and maintenance of risk-reduction goals.

Based on the findings of this assessment, HAA will develop and implement a plan to provide capacity building training on PCM to all sub-grantees that are found to be in need of this training. In addition, HAA will select up to five organizations that will receive individualized, intensive assistance to implement effective interventions and outcome monitoring of PCM.

A plan to conduct outcome monitoring of PCM at those organizations will be developed at the end of 2003, based on the findings of the needs assessment and the results of the technical assistance training plan.